Questions and Answers on the Support Plan and Annual Assessment

September 2007

1. Should the need for "*Routine and emergency medical care and services*" (the need met by Medicaid) only be addressed as a need on the Support Plan if the person is enrolled in the Waiver? Since this is a need that could be assessed for everyone, it really should be addressed for everyone. It must be addressed for anyone who has Medicaid including those enrolled in the MR/RD Waiver.

2. If I have a person receiving Day Habilitation or Facility Based Rehabilitation Supports services, where would I justify these services in the assessment? ***Day Habilitation*** is defined as assistance with the acquisition, retention, or improvement of self-help, socialization and adaptive skills, which take place in a non-residential setting, separate from the home and facility in which the individual resides. ***Facility- Based Rehabilitation Supports*** is defined as a process of providing therapeutic interventions (ex. skills training, care, and supervision) to consumers, who receive services within a licensed day facility, in order to develop, retain or restore an optimal level of functioning in one or more of the following areas:

- Self-Care Skills (ex. eating, toileting, dressing, hygiene, grooming, etc.).
- Community Living Skills (ex. getting from place to place throughout the community (transportation); shopping and purchasing goods and services; use of public buildings/services, financial management, understanding and avoiding health and safety hazards; accessing services (non-emergency and emergency); learning and using problem-solving strategies; preparing meals; operating appliances; use and maintenance of adaptive devices; mobility, etc.).
- Psycho-Social Skills (ex. skills to support a positive impact on self or others; self-determination skills; understanding and practicing responsible behavior; protecting self from victimization; advocacy skills; exercising legal rights; obeying rules/laws; developing and maintaining natural supports, receptive and expressive communication skills; recreation or leisure understanding and participation, etc.).
- Medication Management / Symptom Reduction Skills (ex. self-administration of medication or treatment; basic identification and monitoring of medication side effects; basic understanding how one's diet/exercise effects medication outcomes; basic understanding a health condition; coping strategies that helps to manage symptoms of mental illness including relaxation, hallucination control exercises, and cognitive strategies for delusions, etc.).

Individual Rehabilitation Supports is defined as therapeutic interventions and assistance to improve a condition or to promote/retain an optimal level of functioning in a person with a disability. The scope of Individual Rehabilitation Supports is sufficient to develop enhanced capacity for successful community

living (e.g. greater independence, self-direction, and participation in community activities) and thus reduce the degree of impairment and/or dependency. Individual Rehabilitation Supports (RS/I) services may be provided in the individual's home, natural environment and/or other appropriate community settings. This option is provided on an individually determined schedule and focuses on individual skills, which promote interactions with people who do not have disabilities. Individualized goals and objectives are developed based on assessed and prioritized needs in the areas of:

 Self-Care Skills (ex. eating, toileting, dressing, hygiene, grooming, etc.).
 Community Living Skills (ex. getting from place to place throughout the community (transportation); shopping and purchasing goods and services; use of public buildings/services, financial management, understanding and avoiding health and safety hazards; accessing services (non-emergency and emergency); learning and using problem-solving strategies; preparing meals; operating appliances; use and maintenance of adaptive devices; mobility, etc.).
 Psycho-Social Skills (ex. skills to support a positive impact on self or others; self-determination skills; understanding and practicing responsible behavior; protecting self from victimization; advocacy skills; exercising legal rights; obeying rules/laws; developing and maintaining natural supports, receptive and expressive communication skills; recreation or leisure understanding and participation, etc.).
 Medication Management / Symptom Reduction Skills (ex. self-administration of medication or treatment; basic identification and monitoring of medication side effects; basic understanding how one's diet/exercise effects medication outcomes; basic understanding a health condition; coping strategies that help to manage symptoms of mental illness including relaxation, hallucination control exercises, and cognitive strategies for delusions, etc.).

Therefore, the need for these services could be justified in many areas of the assessment (i.e. Health, Activities/Skills/Abilities, Emotional/Mental/Behavioral Health, Transportation, Community Connections, etc.). The area where the service is justified will depend on the assessed need as it relates to the service definition.

Day Habilitation and Facility- Based Rehabilitation Supports would not be listed in the chart section under vocational. However, you may still check whether they work or not in the first question of the section. It is recommended that any services, such as Day Hab, Rehab Supports or Residential Hab, which may not be listed in a chart, be mentioned in the comments box for the appropriate section noting whether the service is effective and whether the person is satisfied w/ service and provider.

3. Can the Service Coordinator (SC) be listed as an informant on the first page of the assessment? No – the Service Coordinator is the person completing the form. If the person just transferred form another county or was transferred from another caseload, then the current Service Coordinator may list a previous Service Coordinator as an informant.

4. Should the person receiving services be listed as an informant on the first page of the assessment? Yes. Minors may also be listed as informants if they provide information.

5. What should I list as sources of information on the first page of the assessment? Any reports/informants from which you gathered information in order to complete the assessment. Reports should be current, meaning that a report provides information that is reflective of the person's current life/situation/ability.

6. Who gets copies of the Assessment and Plan? The only person required to get a copy of the Support Plan is the person/legal guardian. If the person receiving services also requests a copy of the Assessment, then it should be provided. There is no requirement that program area staff be provided a copy of the Plan. If requested, a copy of the Support Plan/Assessment may be provided if permission to release is granted by the person/legal guardian.

7. What information should be provided to Facilitators? The "Consumer at a Glance" page should be sent to the facilitator at least 7 calendar days before the facilitated plan meeting. Also, please remember, Service Coordinators should assist the facilitator in gathering contact information for people to be invited to the plan meeting if requested.

8. If the person has been assessed to need additional help with identifying personal goals and chooses facilitation as the service in addressing that need, can the support plan meeting and the facilitated plan meeting be held separately? Yes. Facilitation is no longer linked to annual support planning. It is not necessary to have the facilitated meeting in conjunction with the Support Plan. However, if preferred by the person/legal guardian, meetings can be held together. Please also remember that a meeting is not required to develop the Support Plan.

9. Since facilitation is no longer linked to the annual planning process, are Service Coordinators required to attend a facilitated plan meeting if it is not held in conjunction with the plan meeting? No, however, it is best practices for the Service Coordinator to attend the facilitated planning meeting if the person receiving services requests for the SC to attend.

10. The Service Coordinator has to complete the assessment at least the day before the annual Service Coordination Support Plan meeting or Service Coordination Support Plan completion date. What is the timeframe for submitting this information to the facilitators? If facilitation is needed, it should be added to the Support Plan, including the SC responsibilities for coordinating the service and the timeframe for completion. The demographic information from CDSS (Consumer at a Glance) will be sent to the chosen facilitator as authorization for the service.

11. Under current resources, SSA is not listed is it acceptable to check other and write SSA? No. The SC should be choosing SSDI.

12. Can you list the specific drug names on the Assessment? Yes. It is not wrong to list the medications, but it is not required.

13. What is Donna Fletcher's (Office of Plan Review's) role in reviewing plans? Plans will continue to be reviewed; however, the reviews will no longer be done prior to implementation. Instead, Service Coordinators will implement plans as indicated in the plan guidance. Plans chosen as part of the 5% sample should be sent for review upon completion without waiting for approval for implementation. If corrections are needed based on the plan review, the Service Coordinator will make those corrections, submit the corrections to his/her Supervisor, all while continuing the implementation of the plan. A memo explaining this process with a copy of the revised review disposition was mailed July 31, 2007.

Note: Donna Fletcher no longer reviews plans. Plans will be reviewed by Dawn Shealy in District 1 and by Susan Miller in District 2. A memo will be forthcoming to confirm this. Please begin submitting plans to Dawn or Susan for review.

14. What things will the Office of Plan Review be looking for in the Assessment and Plan? The revised Plan Review Disposition form was sent to providers recently. The following will be reviewed:

Assessment:

- Form is complete (all applicable sections/domains/questions must be completed)
- Correct Waiver service names and provider types
- Consistent information throughout the document. For example, if someone needs assistance with catheter/bowel care as indicated in question 3,S section E., then this should also be consistent in the *Personal Care* chart in section E. Another example would be if someone expresses they want a job and this is noted as such in the *Vocational* section of the Assessment, then this should also be identified as a personal priority in the *Personal Priorities* section of the Assessment.
- RN supervision for attendant care services funded by the HASCI Waiver

should be indicated at question 10 in the Health Section.
- If a person is supervising their own attendant - training from a nurse is required . This should also be noted at question 10.

Assessment Summary and Planning Document

-Need(s) identified in the Assessment are addressed on the *Assessment Summary and Worksheet.* Some areas in the assessment will identify numerous needs that can be grouped together into one global needs statement. Needs that are addressed via the Waiver must have a specific needs statement and may not be grouped (See question 27 on this document for specifics).
- There is an explanation for needs that are not being carried over to the Plan.

Support Plan:
- Service Coordination status is indicated.
- Explains monitoring schedule if current circumstances indicate a need for increased monitoring.
- Lists Compliance Officer Information.
- Includes information about the person's emergency/disaster plan in the event of an emergency, natural disaster (refer to question #24 of this document for specifics).
- Include information about the person's emergency plan in the event of an unscheduled absence by the/a caregiver (including a back-up plan for HASCI Attendant Care services) so the person's needs are met and his/her health, safety, and welfare are assured(refer to question #24 of this document for specifics).
- Reflects all identified needs from the *Assessment Summary and Worksheet*.
- Includes a need for each Waiver service.
- Includes the exact or acceptable Waiver service name
- Includes a funding source for each need.
- Includes the amount, frequency and duration for each Waiver service (the same as shown on the Authorization).
- Includes the provider type for each Waiver service.
- Includes the need, frequency and intensity of nurse supervision for HASCI Attendant Care services (this will be noted on the Needs page of the Support Plan under the Service Coordinator's responsibilities and may be stated such as "SC will receive and review nursing supervision notes every 120 days . Completion date : 365 days from plan date".
–Includes a statement that supervision of HASCI Attendant Care services may be furnished directly by the person receiving services/responsible party (when the person/responsible party has been trained to perform this function) and that the supervision by the person/responsible has been certified in writing by a registered nurse.
-Lists responsibilities/timeframes of the Service Coordinator in relation to the provision of the service/intervention identified (refer to question 25 of this document).
- Lists responsibilities/timeframes of the person/legal guardian in relation to the provision of the service/intervention identified (refer to question 25 of this document)..

15. Why is there no demographic or contact information on the plan?

The plan is a way to express what services/supports will be coordinated during the coming year. Demographic information does not contribute to the Plan (i.e.,

does not describe the services/supports to be provided); therefore, it was not included. Likewise, the Assessment is a tool for assessing the person's current situation including their strengths, abilities, needs, resources, etc. Demographic information does not contribute to the Assessment and, therefore, was not included.

16. When we group needs together, is it acceptable to group waiver needs together? There must be a need or group of needs listed for every discrete Waiver service. Groups of needs may be combined (e.g., needs care, needs supervision, and needs skill training) to collectively justify the need for one Waiver service (e.g., Residential Habilitation). However, you may not list one need (e.g., needs care) then list multiple services (e.g., Respite, Day Habilitation and PCA II) as services to meet the need.

17. Where can I group needs together to develop a global needs statement? Every Waiver service MUST have a separate needs statement. Refer to question 16 above. Also, other areas that may be considered for grouping are the following: Community Connections, Natural Supports, Rights, Personal Priorities, Behavioral, etc. For example, if there are questions that identify specific behaviors as needs in the behavioral section (e.g. defiance, physical aggression, and verbal aggression) as well as other needs indicated in the behavioral section, it would be okay to have a global need statement to say "John needs to improve behavioral and emotional health". It is recommended to look at the section/domain heading and determine whether the section/domain heading could be put into a needs statement. When automated, there will be a computerized worksheet to assist in determining how needs can be grouped to develop a global needs statement.

18. Do residential/day goal dates have to match with the Support Plan? No. Residential and Day have their own plan that addresses specific residential or day needs identified via their assessments. Service Coordinators are listing global need statements on the Support Plan.

19. Can you reference documents/reports/service plans in the Assessment? Yes. Documentation for use of documents/reports/service plans must be noted in the *Sources of Information* section on the first page of the Assessment.

20. When answering questions regarding rights with children/minors, how do you answer those questions? Some of the questions may be answered by the child, such as numbers 1 – 4 in the "Self-Advocacy and Rights" section of the Assessment. However, most of the questions will be directed to the legal guardian and whether the legal guardian understands and exercises their rights in lieu of the child. The same would be true for adults with legal guardians.

21. Can we use the new monitoring forms with the Single Plan document? Yes. Keep in mind that there has to be one monitoring form for every need on the Plan at least quarterly (or as defined).

22. Time limited dates are important where should this be addressed on the assessment so that they are easily identified? This topic is not specifically covered by the Assessment. There is no right or wrong place to include the information. We suggest the comments section at "Current Resources" since DDSN eligibility does provide resources.

23. Is it acceptable to hand write that the person receiving services is being served under a time limited category on the first page of the assessment so that it is easily identified? No, there is not space available to write this information. Keep in mind that automation of the Assessment will not entail a space for that information, so it is recommended not start a practice that would not be continued upon automation of the documents.

24. Should the next plan due date be the date that the upcoming plan is due by or the day that I complete the plan? It is the last possible date by which the upcoming plan is due. For example, my current plan is dated 9/1/2006. The new plan is due no later than August 31, 2007; therefore, the next plan due date documented on the Assessment would be August 31, 2007. The next plan may be completed prior to August 31, 2007, but must be completed no later than August 31, 2007.

25. Should the Service Coordinator talk to all people referenced in the guidance for the assessment, page 1, when gathering information to complete the assessment? The SC should collect information from all people involved in the person's life to gather information. If the appropriate information is provided via written reports, then "talking" many not be needed. Also, the people mentioned in the guidance may not be applicable for all people served. For example, the SC would not talk to Day Program staff if the person does not receive Day Program services.

26. On page 3 of the guidance for the assessment, an example was given regarding respite and the provider type for respite…are we suppose to list respite in the chart under the health section? No. We used respite merely as an example for the provider type. Any respite information will be reflected under the *Living Environment* section of the Assessment. This was not an appropriate example for that section of the assessment, but was merely to reflect what a provider type is.

27. What are you looking for in the Support Plan for emergency planning?

There are two areas to complete in the Support Plan for emergency planning:

a. **How, in the event of an unscheduled absence by the/a caregiver, will this person's needs be met so that his/her health, safety, and welfare are assured?** The SC will note all caregivers – paid and natural – and what will happen if there is an unscheduled absence of those caregivers. For example, if a person has a paid caregiver for 8 hours a day (PCA, ATTC), the Service

Coordinator may note that the agency providing care will provide a back-up caregiver if the regular caregiver/s is/are absent. If the Service Coordinator notes that the parents provide care the remaining time, the SC may note that another family member, such as an aunt or sibling (list name and contact number/s), would provide care if the parents are not able to.

b. **How will emergency situations, such as natural disasters, be managed by or on behalf of this person?** The SC will address, at least, the following 3 areas: 1) who will be responsible for the person during emergencies and their contact information 2) where the person would evacuate if evacuation is required (list specific shelter information) and 3) and what transportation will be used for evacuation purposes. Other things to consider, especially if someone lives alone, is can the person dial 911? Exit their home w/o assistance? Coordinate transportation?

Note: For people residing in a DDSN sponsored residential setting, the Service Coordinator will need to note that the residential provider will provide back-up care if there is an absence of staff. For emergencies/natural disasters, the SC will need to note that the residential provider staff are responsible with a contact number, where the residence will evacuate to and that the residential provider will transport the person if evacuation is required.

28. What are you looking for in the "Service Coordinator's and Person/ Legal Guardian's Responsibilities" section on the Support Plan?

a. Service Coordinator's Responsibilities related to Service/Intervention and Timeframes/Expected Completion Dates:

When thinking about the SC's responsibilities note the specific steps in arranging for and maintaining a service/intervention and an expected completion date or timeframe. For example, a new need being identified for the first time may have the following responsibilities listed:

1. Offer choice of provider (give timeframe/completion date)
2. Authorize the service (give timeframe/completion date)
3. Monitor the service according to the service guidelines (give timeframe/completion date). If a service/intervention is provided which does not require a specific monitoring schedule, then the SC must monitor the need at least quarterly
4. Make changes to the plan as notified or necessary to ensure effectiveness and satisfaction(give timeframe/completion date)

For example, an on-going need may have:

1. Monitor the service/intervention according to service guidelines (give timeframe/completion date).
2. If a service/intervention is provided which does not require a specific monitoring schedule, then the SC must monitor the need at least quarterly (give timeframe/completion date).

b. Person/Legal Guardian's Responsibilities related to Service/Intervention and Timeframes/Expected Completion Dates:

Note specifically what the person/legal guardian will be expected to do.

For example, a new need may have the following:

1. Person will choose providers from list of approved providers (target date/timeframe)
2. Person will obtain bids for a vehicle modification from 3 providers (target date/timeframe)
3. Person will participate in the service (365 days from plan date)
4. Person will notify the SC of any changes needed or any issues (365 days from Plan date)

For example, an on-going need may have the following:

1. Person will participate in the service (365 days from plan date)
2. Person will notify the SC of any changes needed or any issues (365 days from plan date)

Responsibilities assigned should make sense according to the need and the service/intervention/support that will address the need. If there are specific questions pertaining to this section of the Support Plan, please ask your supervisor for assistance/guidance and/or call District Office Service Coordination staff to talk through this.

29. **Where do I note nursing supervision for Attendant Care Services?** Nursing supervision for ATTC services should be justified in the assessment and noted at the question pertaining to nursing judgement in the medical section. Nursing supervision will also be noted on the Support Plan under the SC's responsibilities…a statement such as "SC will receive and review Nursing supervision notes every 120 days".

30. **It was stated that you would list a consumer's name under B, page 1 of the Assessment, Sources of Information, # 1… People providing input. If a consumer is non-verbal and unable to provide any information, then it was stated that by observing the consumer, you can see that he is content, happy, etc. We think that you would put that under #2, Records/Reports Used (where you would put observations of the person). Is this correct?** Observation of a person is not necessarily receiving direct input from a person ...it is a report of an observation. However, we should be soliciting input from people served regardless of how they communicate and, if you don't know how they communicate, you should be learning so that information can be solicited. So, if a person is non-verbal, you would be getting input from observation. Regardless of how it is documented, if observation was used in completing the Assessment, it should be noted in either area of Sources of Information on the first page of the Assessment. What is important is that information obtained is used and documented.

31. **For the chart on p. 3 of the Assessment, how would you write the need for the medical conditions? Would you say that the person needs to maintain best possible health? Would you say they need treatment for their medical**

conditions? Or would you be specific and say, "Johnny needs treatment for his diabetes, hypertension, seizure disorder, etc? It is suggested to use either of the first two options in the question above. These statements are general and could include any additional medical situation that might occur during the year. The third option covers current conditions, but if he gets the flu, breaks a bone, etc---you'd have to do an additional "Need page"---the first two options would cover anything.

32. **Where would you include the need for summer support/option funds? Would you not indicate "yes" for question 2 on page 4 (I would say no because summer support/option is not a basic need)?** Summer funds are used for respite services, especially for those over 12 with special needs. It could be noted as need of supervision during absence of a caregiver while not in school. If someone is currently receiving these funds (as could happen for Assessments done in the summer), you could include this under #1---they are a current resource. The Need for summer services might come up on P. 16 in "Community Connections", or under "Natural Supports"--#5 if his summer service brings him together with friends, or "Personal Priorities" if the summer activity is a personal goal---i.e., to attend camp. It could also be identified appropriately on P 17, #1—making choices for recreation/leisure. On the needs page of the Support Plan, you'd indicate Summer Support Service funds as the funding source.

33. **If the SC realizes that they did not include a need from a shaded box on the assessment (after the plan has been implemented), would you need to contact that consumer to add that need to the plan?** Yes, you should contact the consumer---certainly if it is something that will be added to Plan. If, however, it is something that was discussed and you know it won't be added to Plan, I'd suggest writing a service note to document that something was omitted from the Summary.

34. **For the provider type---this came from the list in the waiver manual. If its adult dental, would you list all the types like licensed dentist, oral surgeon, or dental hygienist or just one?** Refer to the charts in the Waiver manuals for provider type. It seems most logical to document the licensed dental.

35. **How do you make changes to the Assessment?** Changes are not made to the Assessment during the course of the planning year. The Assessment is considered to be a "snapshot" in time completed for the purpose of developing the Support Plan. If new needs or changes in a person's life are identified during the Plan year, then the SC will need to document this in the Service Notes and add to the Support Plan per Support Plan guidance.

36. **Do we have to write "formulated" and "implemented" in the service notes for the Plan anymore?** Not "formulated". "Formulated" was a term used to allow for review of the previous plan (Single Plan) prior to implementation or was to allow for a Facilitated Plan to be approved prior to implementation. Plan

implementation is a core job function of the Service Coordinator and it is encouraged to use "plan implementation" in the service notes to be very clear when the SC is performing a function where he/she is implementing a process to meet a need on the Plan.

37. **Do we have to offer Facilitation any longer?** Providing information to service users and families about the services available in order to enable them to make informed choices is expected. However, it is not expected that the offering and documentation of the response to the offering of facilitation be documented annually in conjunction with Support Planning as has been required. It is, however, expected that it be offered when the Assessment indicates the service user needs assistance to identify personal goals/priorities.

38. **How should Assistive Technology units be listed on the Plan?** The way a unit of Assistive Technology is listed on the plan has not changed from the previous plan. Specialized supplies and adaptations/assistive tech items will be noted on the plan by providing the amount (quantity), frequency (how often received), duration (how long will receive) and dollar amount of the item/s. They will be listed on the Needs Page of the plan in the indicated box.

39. **Is the Assessment for Level I consumers only?** Yes except for a person who is in Intake and the Assessment has been initiated.

40. **If there is no meeting, the family and consumer do not sign anything on the Support Plan?** No. The signing of the plan by the service user or the legal guardian is not required. The only signature required on the plan is that of the Service Coordinator.

41. **Once automation begins will the Service Coordinators be able to make changes/corrections on a completed plan?** The way changes/corrections will be made is by completing a "Needs Change" (the same as the needs change box being used now) or by adding a new needs page to the Plan.

42. **How do you show on the Assessment if a person desires a change in providers?** It could be noted in a chart (if the service is listed in a "Service/Support" chart) or in the comments section of the area for which the service would fall (if it is a service that is not noted in a chart). Provider change would not be reflected as a need. The need will remain the same and the plan will reflect one of the SC's responsibilities is to "offer choice of provider since the person is not satisfied with their current provider". The responsibilities of the person would be to "choose a new provider since person is not satisfied with current provider". For provider changes during the course of the planning year, the SC would note them in the service notes and/or on the monitoring forms.

43. How is PERS (Personal Emergency Response System) justified? Some services are not listed in charts on the Assessment. However, all services must be justified in the Assessment. PERS is one service that may or may not be listed in a chart – it depends on the individual and what their need is. For example, the Personal Care/Daily Living Charts should show when supervision is not being provided or a need for supervision. PERS also may show up because someone lives alone at home and cannot access 911 or basic transportation to meet an emergency need – the SC would comment in the comments box that the person receives PERS. Also, it may be noted in the Living Environment section, question 1b. If the person has PERS, the SC could indicate "no" to this question, and then make a comment that the person would not appear safe if they did not have the PERS. By indicating "no" on this question, it would force a need to be carried over to the summary. There is no right or wrong place to justify this service as long as, if someone is receiving and is to continue the service, that there is a need identified on the Assessment.